

SUMMARY OF BENEFITS

Institute on Aging






























Kaiser

7/1/2024

to

6/30/2025

HMO Plan (California)

TYPE OF VISIT	YOU PAY	DIFFERENCE CARD PAYS	KAISER BENEFIT
DEDUCTIBLE & COINSURANCE			
Qualified High Deductible Health Plan		No	
Deductible Accumulation Period		Calendar Year	
Family Deductible Accumulation Type		Yes	
 In-Network Individual Deductible	Last \$500	First \$2,500	\$3,000
 In-Network Family Deductible	Last \$3,500	First \$2,500	\$6,000
Out-of-Network Individual Deductible		No out of Network	
Out-of-Network Family Deductible		No out of Network	
Prescription Deductible Application		N/A	
Prescription Individual Deductible		No Prescription Deductible	
Prescription Family Deductible		No Prescription Deductible	
In-Network Coinsurance %	30%	0%	30%
In-Network Individual Coinsurance Limit	\$3,000	\$0	\$3,000
In-Network Family Coinsurance Limit	\$6,000	\$0	\$6,000
Out-of-Network Coinsurance %		No out of Network	
Out-of-Network Individual Coinsurance Limit		No out of Network	
Out-of-Network Family Coinsurance Limit		No out of Network	
In/Out Network Cross Accumulation		No	
PHYSICIAN SERVICES			
 Primary Care Office Visit Copay	Remaining Charges	First \$2,500	Deductible & Coinsurance
 Specialist Office Visit Copay	Remaining Charges	First \$2,500	Deductible & Coinsurance
Telemedicine Copay		No Charge	
Other (Chiro) Office Copay	N/A	N/A	N/A
PREVENTIVE CARE			
Preventive Care / Screening / Immunization		No Charge	
DIAGNOSTIC PROCEDURES			
 Diagnostic Test X-Ray	Remaining Charges	First \$2,500	Deductible & Coinsurance
 Diagnostic Test- Lab Bloodwork	Remaining Charges	First \$2,500	Deductible & Coinsurance
 Imaging (CT/Pet Scans, MRIs)	Remaining Charges	First \$2,500	Deductible & Coinsurance
PHARMACY			
 Tier 1 RX Retail Copay	\$25	50%	30% up to \$50
 Tier 1 RX Mail Order Copay			
 Tier 2 RX Retail Copay	\$50	50%	30% up to \$100
 Tier 2 RX Mail Order Copay			
 Tier 3 RX Retail Copay	\$125	50%	30% up to \$250
 Tier 3 RX Mail Order Copay			
 Tier 4 RX Retail Copay	\$75	50%	20% up to \$150
 Tier 4 RX Mail Order Copay	N/A	N/A	N/A
MAJOR MEDICAL SERVICES			
 Outpatient Surgery Facility Fee	Remaining Charges	First \$2,500	Deductible & Coinsurance
 Outpatient Surgery Physician / Surgeon Fee	Remaining Charges	First \$2,500	Deductible & Coinsurance
 Emergency Room Care	Remaining Charges	First \$2,500	Deductible & Coinsurance
 Emergency Medical Transportation	Remaining Charges	First \$2,500	Deductible & Coinsurance
 Urgent Care	Remaining Charges	First \$2,500	Deductible & Coinsurance
 Inpatient Hospital Facility Fee	Remaining Charges	First \$2,500	Deductible & Coinsurance
 Inpatient Surgery Physician / Surgeon Fee	Remaining Charges	First \$2,500	Deductible & Coinsurance
 Behavioral Health Outpatient Services	Remaining Charges	First \$2,500	Deductible & Coinsurance
 Behavioral Health Inpatient Services	Remaining Charges	First \$2,500	Deductible & Coinsurance
Prenatal and Postnatal Care		No Charge	
 Delivery and All Inpatient Services	Remaining Charges	First \$2,500	Deductible & Coinsurance
Home Health Care		No Charge	
 Rehabilitation Services	Remaining Charges	First \$2,500	Deductible & Coinsurance
 Habilitative Services	Remaining Charges	First \$2,500	Deductible & Coinsurance
 Skilled Nursing Care	Remaining Charges	First \$2,500	Deductible & Coinsurance
 Durable Medical Equipment	Remaining Charges	First \$2,500	Deductible & Coinsurance
Hospice Service		No Charge	

Family Multiplier 2

Mail Order Multiplier 2

All claims must be submitted within 3 months of the end of the deductible accumulation period.

Terminated members must submit claims within 3 months of the termination date.

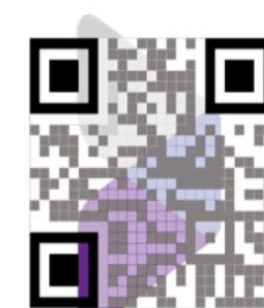
Information on this document based on carrier SBC

Please have your provider swipe the Difference Card for the following amounts:

Primary Care & Specialist Swipe -	First \$2,500
ER Visit Swipe -	First \$2,500
Urgent Care Swipe -	First \$2,500
Rx Swipe -	50%
Deductible Expenses -	Up to \$2500

Call 888.343.2110 with any questions.

Download the Mobile App to View and Submit Claims



SCAN THIS WITH YOUR CAMERA



SUMMARY OF BENEFITS

Institute on Aging

United Healthcare

7/1/2024 to 6/30/2025

Core PPO Plan

TYPE OF VISIT	YOU PAY	DIFFERENCE CARD PAYS	UHC BENEFIT
DEDUCTIBLE & COINSURANCE			
Qualified High Deductible Health Plan	No		
Deductible Accumulation Period	Calendar Year		
Family Deductible Accumulation Type	Embedded		
In-Network Individual Deductible	Last \$500	First \$3,000	\$3,500
In-Network Family Deductible	Last \$4,000	First \$3,000	\$7,000
Out-of-Network Individual Deductible	\$10,500	\$0	\$10,500
Out-of-Network Family Deductible	\$21,000	\$0	\$21,000
Prescription Deductible Application	N/A		
Prescription Individual Deductible	No Prescription Deductible		
Prescription Family Deductible	No Prescription Deductible		
In-Network Coinsurance %	30%	0%	30%
In-Network Individual Coinsurance Limit	\$3,500	\$0	\$3,500
In-Network Family Coinsurance Limit	\$7,000	\$0	\$7,000
Out-of-Network Coinsurance %	50%	0%	50%
Out-of-Network Individual Coinsurance Limit	\$10,500	\$0	\$10,500
Out-of-Network Family Coinsurance Limit	\$21,000	\$0	\$21,000
In/Out Network Cross Accumulation	No		
PHYSICIAN SERVICES			
Primary Care Office Visit Copay	\$0	\$30	\$30 Copay
Specialist Office Visit Copay	\$0	\$60	\$60 Copay
Telemedicine Copay	No Charge		
Other (Chiro) Office Copay	\$0	\$30	\$30 Copay
PREVENTIVE CARE			
Preventive Care / Screening / Immunization	No Charge		
DIAGNOSTIC PROCEDURES			
Diagnostic Test X-Ray	Remaining Charges	First \$3,000	Deductible & Coinsurance
Diagnostic Test- Lab Bloodwork	Remaining Charges	First \$3,000	Deductible & Coinsurance
Imaging (CT/Pet Scans, MRIs)	Remaining Charges	First \$3,000	Deductible & Coinsurance
PHARMACY			
Tier 1 RX Retail Copay	\$10	\$0	\$10.00
Tier 1 RX Mail Order Copay	\$25	\$0	\$25.00
Tier 2 RX Retail Copay	\$35	\$0	\$35.00
Tier 2 RX Mail Order Copay	\$87.50	\$0	\$87.50
Tier 3 RX Retail Copay	\$70	\$0	\$70.00
Tier 3 RX Mail Order Copay	\$175	\$0	\$175.00
Tier 4 RX Retail Copay	\$10/\$150/\$250	\$0	\$10/\$150/\$250
Tier 4 RX Mail Order Copay	N/A	\$0	N/A
MAJOR MEDICAL SERVICES			
Outpatient Surgery Facility Fee	Remaining Charges	First \$3,000	Deductible & Coinsurance
Outpatient Surgery Physician / Surgeon Fee	Remaining Charges	First \$3,000	Deductible & Coinsurance
Emergency Room Care	Remaining Charges	First \$3,000	Deductible & Coinsurance
Emergency Medical Transportation	Remaining Charges	First \$3,000	Deductible & Coinsurance
Urgent Care	\$0 Copay	\$50	\$50
Inpatient Hospital Facility Fee	Remaining Charges	First \$3,000	Deductible & Coinsurance
Inpatient Surgery Physician / Surgeon Fee	Remaining Charges	First \$3,000	Deductible & Coinsurance
Behavioral Health Outpatient Services	\$0	\$30	\$30 Copay
Behavioral Health Inpatient Services	Remaining Charges	First \$3,000	Deductible & Coinsurance
Prenatal and Postnatal Care	No Charge		
Delivery and All Inpatient Services	Remaining Charges	First \$3,000	Deductible & Coinsurance
Home Health Care	Remaining Charges	First \$3,000	Deductible & Coinsurance
Rehabilitation Services	\$0	\$30	\$30 Copay
Habilitative Services	\$0	\$30	\$30 Copay
Skilled Nursing Care	Remaining Charges	First \$3,000	Deductible & Coinsurance
Durable Medical Equipment	Remaining Charges	First \$3,000	Deductible & Coinsurance
Hospice Service	Remaining Charges	First \$3,000	Deductible & Coinsurance

Family Multiplier 2

Mail Order Multiplier 2.5

All claims must be submitted within 3 months of the end of the deductible accumulation period.

Terminated members must submit claims within 3 months of the termination date.

All Out-of-Network Services are subject to the Deductible Information on this document based on carrier SBC

Please have your provider swipe the Difference Card

for the following amounts:

- Primary Care Swipe - \$30
- Specialist Swipe - \$60
- Urgent Care Swipe - \$50
- Deductible Expense Up to \$3,000

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SUMMARY OF BENEFITS

Institute on Aging









United Healthcare

7/1/2024

to

6/30/2025

Select Plus PPO Plan

TYPE OF VISIT	YOU PAY	DIFFERENCE CARD PAYS	UHC BENEFIT
DEDUCTIBLE & COINSURANCE			
Qualified High Deductible Health Plan	No		
Deductible Accumulation Period	Calendar Year		
Family Deductible Accumulation Type	Embedded		
 In-Network Individual Deductible	Last \$500	First \$3000	\$3,500
 In-Network Family Deductible	Last \$4,000	First \$3,000	\$7,000
Out-of-Network Individual Deductible	\$6,000	\$0	\$10,500
Out-of-Network Family Deductible	\$12,000	\$0	\$21,000
Prescription Deductible Application	N/A		
Prescription Individual Deductible	No Prescription Deductible		
Prescription Family Deductible	No Prescription Deductible		
In-Network Coinsurance %	30%	0%	30%
In-Network Individual Coinsurance Limit	\$3,500	\$0	\$3,500
In-Network Family Coinsurance Limit	\$7,000	\$0	\$7,000
Out-of-Network Coinsurance %	50%	0%	50%
Out-of-Network Individual Coinsurance Limit	\$10,500	\$0	\$10,500
Out-of-Network Family Coinsurance Limit	\$21,000	\$0	\$21,000
In/Out Network Cross Accumulation	0		
PHYSICIAN SERVICES			
 Primary Care Office Visit Copay	\$0	\$30	\$30 Copay
 Specialist Office Visit Copay	\$0	\$60	\$60 Copay
Telemedicine Copay	No Charge		
 Other (Chiro) Office Copay	\$0	\$30	\$30 Copay
PREVENTIVE CARE			
Preventive Care / Screening / Immunization	No Charge		
DIAGNOSTIC PROCEDURES			
 Diagnostic Test X-Ray	Remaining Charges	First \$3,000	Deductible & Coinsurance
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Tier 1 RX Mail Order Copay	\$25	\$0	\$25.00
Tier 2 RX Retail Copay	\$35	\$0	\$35.00
Tier 2 RX Mail Order Copay	\$87.50	\$0	\$87.50
Tier 3 RX Retail Copay	\$70	\$0	\$70.00
Tier 3 RX Mail Order Copay	\$175	\$0	\$175.00
Tier 4 RX Retail Copay	\$10/\$150/\$250	\$0	\$10/\$150/\$250
Tier 4 RX Mail Order Copay	N/A	\$0	N/A
MAJOR MEDICAL SERVICES			
 Outpatient Surgery Facility Fee	Remaining Charges	First \$3,000	Deductible & Coinsurance
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 Urgent Care	\$0 Copay	\$50	\$50
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 Durable Medical Equipment	Remaining Charges	First \$3,000	Deductible & Coinsurance
 Hospice Service	Remaining Charges	First \$3,000	Deductible & Coinsurance

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